State: *Arkansas* ***Filing Company:*** *Kilpatrick Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Life application*
Project Name/Number: */*

Filing at a Glance

Company:	Kilpatrick Life Insurance Company
Product Name:	Life application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	01/16/2013
SERFF Tr Num:	EWLE-128852804
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	
Author(s):	Suzanne Heasley
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/22/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* ***Filing Company:*** *Kilpatrick Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Life application*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type:
Filing Status Changed: 01/22/2013
State Status Changed: 01/22/2013
Created By: Suzanne Heasley
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Suzanne Heasley

Filing Description:
See attached submission letter

Company and Contact

Filing Contact Information

Suzanne Heasley, Compliance
2325 Havard Oak Drive
Plano, TX 75074

sheasley@lewisellis.com
972-398-3733 [Phone]

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated3)

Kilpatrick Life Insurance Company
1818 Marshall Street
Shreveport, LA 71161
(318) 222-0555 ext. [Phone]

CoCode: 74918
Group Code:
Group Name:
FEIN Number: 72-0229180

State of Domicile: Louisiana
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
Kilpatrick Life Insurance Company	$50.00	01/16/2013	66602755

SERFF Tracking #:	*EWLE-128852804*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Kilpatrick Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life application*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/22/2013	01/22/2013

SERFF Tracking #:	*EWLE-128852804*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Kilpatrick Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life application*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/22/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization to file		Yes
Supporting Document	Submission letter		Yes
Form	Application		Yes

SERFF Tracking #:	*EWLE-128852804*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Kilpatrick Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life application*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:								
Item No.	**Schedule Item Status**	**Form Name**	**Form Number**	**Form Type**	**Form Action**	**Action Specific Data**	**Readability Score**	**Attachments**
1		Application	App.4.5.6.AR REV 12/12	AEF	Initial			LongAppArkansasupdatedNov2012.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

KILPATRICK LIFE INSURANCE COMPANY

1818 Marshall Street, Shreveport, Louisiana 71101

APPLICATION FOR INSURANCE

APPLICATION NO. _____ **PRENEED. _____**

AGENCY_____ **RT._____** **LOC._____** **APPLICATION PART 1**

1. Primary Proposed Insured (Please print full name)	6. Date of Birth Month Day Year	10. Employer
2a. Mailing Address (Street, RFD or Box Number)		Employer's Address
City State Zip Code	7. Birth Place (State or Country) / 8. Age	City or Town / State / Zip Code
Physical Description of Collection Location	9. Occupation	Telephone No. / Date Employed

2b. **Payor's Physical Address** (Street) (City) (State) (Zip Code)

3. Sex ☐ M ☐ F	4. Soc. Sec. No.	5a. Home Phone No. ( ) - 5b. Cell Phone No. ( ) -	11. Annual Income (CAPP ONLY) $	12. Net Worth (CAPP ONLY) $

COVERAGE DETAILS

13. Plan Code 14. Plan Description	15. Amount of Insurance $	16. Benefits / Riders ☐ADB $_____ ☐CTR $_____ ☐GIR $_____ ☐Accelerated Living Benefit ☐Persistency Benefit Enhancement ☐Waiver of Premium ☐Payor Waiver of Premium

17. Premium a. Modal Premium $_____ Cash with Application $ _____

b. Payable ☐A ☐S ☐Q ☐M ☐Bank Draft ☐Other_____

18. Children's Term Rider (To be Completed For Each Insured Child)

Full Name	Social Security No.	Date of Birth	Age	Sex	Insurance Owned	Relationship	Height	Weight

19. Owner (If other than Primary Proposed Insured)

Full Name _____ Relationship_____

Address _____

Telephone _____ So. Sec. No. _____

Date of Birth _____ Age _____

20. Payor (If other than Primary Proposed Insured)

Full Name _____ Relationship_____

Address _____

Telephone _____ So. Sec. No. _____

Date of Birth _____ Age _____

21a. Primary Beneficiary

Full Name _____ Relationship_____

Address _____

Age ____ Telephone _____ So. Sec. No. _____

21b. Contingent Beneficiary

Full Name _____ Relationship_____

Address _____

Age ____ Telephone _____ So. Sec. No. _____

22. Existing Life Insurance (List Below)

Is replacement of existing insurance involved in this application)?..... YES ☐ NO ☐

Name of Company	Date of Issue	Life Amount	Purpose Business / Personal	Accidental Death Benefit Amount	Replacement YES	Replacement NO
					☐	☐
					☐	☐
					☐	☐
					☐	☐

If yes: Have you submitted the appropriate replacement forms?..... ☐ ☐

(If there is additional insurance beyond those listed, please list on a separate sheet)

Please provide details to "Yes" answers in Remarks Section

Has Proposed Insured, any dependent child or payor proposed for coverage,:

	YES	NO
23. a) smoked any cigarettes within the past 12 months?	☐	☐
b) use tobacco in any other form?	☐	☐
24. within the past 5 years:		
a) been charged with driving while impaired (alcohol, drugs, other) violation, had a drivers license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	☐	☐
b) had an application for insurance declined, rated, or postponed?	☐	☐
c) flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐
d) engaged in parachuting, racing or other hazardous sport or intend to do so?	☐	☐
e) used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advise or treatment for alcohol or drug use?	☐	☐
25. Does Proposed Insured intend to travel or reside outside of the U.S.?	☐	☐

26. Primary Proposed Insured:

Height	Weight	Change in Past Year? Yes ☐ No ☐	Cause of Weight Gain / Loss
_____	_____	_____ Lbs. ☐ Gain ☐ Loss	

27. A) Name of usual medical advisor for primary insured?_____

Address _____ Phone _____

Date and reason of last visit?_____

What treatment was given or medication prescribed?_____ If None, then write None here_____

(Current medications to be listed in section 31)

B) Usual medical advisor for dependent child or payor proposed to be listed in section 31.

Has Proposed Insured, any dependent child or payor proposed for coverage,:

	YES	NO
28. ever had, or been told they had, or received treatment or advice for:		
a) abnormal blood pressure, coronary artery disease or any other disease of the heart, blood vessels or cardiovascular system, stroke or any other disease of the cerebrovascular system?	☐	☐
b) cancer, tumor, or any other growth or malignancy?	☐	☐
c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?	☐	☐
d) any nose, throat, lung, or any other respiratory disorder?	☐	☐
e) any disorder of the stomach, intestines, rectum, liver or pancreas?	☐	☐
f) any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐
g) epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system?	☐	☐
h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐
i) any disease or disorder of the kidney, bladder, or genital organs or system?	☐	☐
j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?	☐	☐
29. other than as stated above, within the past 5 years:		
a) consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	☐	☐
b) had any abnormal diagnostic tests?	☐	☐
c) been aware of any symptoms for which a medical advisor has not yet been consulted?	☐	☐
30. had parents and/or siblings with heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease? (CAPP only)(If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death).	☐	☐

31. REMARKS (Explain "Yes" answers to Questions 23-30)

Ques. #	Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

PROPOSED INSURED'S NAME IN FULL

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - KILPATRICK LIFE INSURANCE COMPANY

I, the Proposed Insured, by my signature set forth hereafter

AGREE to the following.

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind KILPATRICK Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.

(d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

ACKNOWLEDGE receipt of the following notices

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB Pre-Notice

Signed at _____, _____ _____ X)_____

City State Date SIGNATURE OF PRIMARY PROPOSED INSURED OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

_____ X)_____

SIGNATURE OF LICENSED AGENT SIGNATURE OF APPLICANT OR OWNER (IF OTHER THAN PROPOSED INSURED)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION:

Name (last, first, middle):_____ Date of Birth: _____

Address:_____ Drivers Lic. No.:_____

City:_____ State_____ Zip Code_____

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE OR EVENT:

Date:_____ Event:_____

Purpose of this Disclosure: LIFE INSURANCE - DISABILITY - DEATH CLAIM

INFORMATION TO BE RELEASED TO KILPATRICK FROM_____

Date of Service_____to_____

☐ Complete Medical Records	☐ History & Physical Exam	☐ Discharge Summary
☐ ER Record	☐ Lab & X-rays	☐ Operative report
☐ Consultation	☐ HIV/AIDS related information	☐ Alcohol/Drug Abuse
☐ Psychiatric Records	☐ Other_____	

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditional on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient (Insured, Parent or Guardian) _____ Date_____

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

NOTICE OF INFORMATION PRACTICES

This Notice Must be Given to Proposed Insured

(Including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB

Information regarding your insurability will be treated as confidential. KILPATRICK LIFE INSURANCE COMPANY, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a not for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file. If you question the accuracy of information MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts, 02184-8734. Please contact MIB at 866-692-6901.

AGENT'S REPORT

1. Agent Checklist (Provide details in Additional Remarks Section below) **YES** **NO**

A. Did you give the applicant a copy of the Privacy Notice and other disclosure information?..... ☐ ☐
B. Are you related to the Proposed Insured?..... ☐ ☐
C. Was this application taken in person?..... ☐ ☐
D. Do you know anything not disclosed which might affect the underwriting of this risk?..... ☐ ☐
E. Is there another application currently pending or being submitted to any other life insurance company?..... ☐ ☐
F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?..... ☐ ☐
G. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms? ..... ☐ ☐
H. List email address for any Proposed Insured below:

_____

2. Financial and Medical Requirement Information:

A. If exam required, give name or examiner, and date exam scheduled or completed _____
B. If required, have or ordered or obtained

☐ Exam ☐ PHI number or Commercial Report ☐ Blood profile/DBS/Specimen
☐ Income verification type: _____ ☐ EKG ☐ Other _____

3. For Policies applied for in excess of $100,000, if proposed insured is married, what amount of insurance does spouse own?

_____

4. For Policies applied for in excess of $25,000, if proposed insured is under 16, show amount of insurance on family members:

Father_____ **Mother**_____

Amount of insurance on brothers and sisters under 16:

Name	**Amount**	**Name**	**Amount**

5. Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.)

A. Is this insurance part of a split dollar agreement? ☐ Yes ☐ No
B. The business operates as a:
☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Propriertorship
C. What is the value of the business? $ _____
D. What percentage does the Proposed Insured own or control? _____%
E. Are other key individuals applying? If yes, indicate name of each person. If no, for what reason? ☐ Yes ☐ No

_____

6. References

Name	**Address**	**Phone**	**Relationship**
(1.)			
(2.)			
(3.)			
(4.)			

7. Additional Remarks

_____

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date: _____ **Agent's Signature X** _____

APPLICATION REVIEWED FOR ACCURACY BY

Signature X _____ **Name**_____ **Date** _____

KILPATRICK LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met:

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt cannot exceed [$100,000.] This includes any previously pending insurance.

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

KILPATRICK LIFE INSURANCE COMPANY

APP NUMBER_____**RECEIVED $** _____**FROM**_____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

By _____ _____ 20_____
Kilpatrick Life Insurance Company Date

SERFF Tracking #:	*EWLE-128852804*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*Kilpatrick Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life application*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR complaint.pdf Compliance certificate AR.pdf Readability certificate AR.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Authorization to file		
Comments:			
Attachment(s):			
Authorization to file.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Submission letter		
Comments:			
Attachment(s):			
AR Submission letter.pdf			

KILPATRICK

LIFE INSURANCE COMPANY

1818 Marshall Street
Shreveport, Louisiana 71101

IMPORTANT INFORMATION

If You have questions about Your Policy or a claim You have filed, please write to our Home Office.

KILPATRICK LIFE INSURANCE COMPANY
P.O. Box 88
Shreveport, Louisiana 71161
1 (800) 235-0555

If we at Kilpatrick Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904
Telephone: (501) 371-2640 or 1 (800) 852-5494

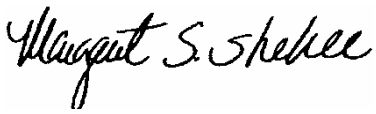
Readability Certification

Insurance Company: Kilpatrick Life Insurance Company

Form Number	**Description of Form**
App.4.5.6.AR REV 12/12	Application for Life Insurance

I hereby certify that in connection with the above referenced form, Kilpatrick Life Insurance Company will comply with the requirements of:

Rule & Regulation 19 pertaining to Unfair Sex Discrimination
Rule & Regulation 49 pertaining to Guaranty Association Notices



Authorized Signature

Margaret S. Shehee
Name

Vice President and Treasurer
Title

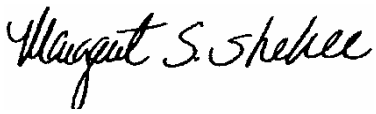
January 16, 2013
Date

Readability Certification

Insurance Company: Kilpatrick Life Insurance Company

Form Number	**Description of Form**
App.4.5.6.AR REV 12/12	Application for Life Insurance

I hereby certify that the above referenced form complies with the readability requirements of this State.



Authorized Signature

Margaret S. Shehee

Name

Vice President and Treasurer

Title

January 10, 2013

Date

KILPATRICK
Life Insurance Company

1818 Marshall Street, P.O. Box 88, Shreveport, LA 71101 318-222-0555

September 27, 2012

To Whom It May Concern:

I hereby authorize the actuarial consulting firm of Lewis & Ellis, Inc. to file life, health, accident and annuity policy forms and rates on behalf of Kilpatrick Life Insurance Company.

This authorization includes the power to certify the exempt status of certain forms, except where prohibited by law.

This authorization will expire (12) months from the date on which it was signed.

John Hensarling
President/CEO

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Wesley R. Campbell, F.S.A.
Jacqueline B. Lee, F.S.A.
Robert E. Gove, A.S.A.
J. Finn Knox-Seith, A.S.A.
Brian C. Stentz, A.S.A.
Jay W. Fuller, A.S.A.
Sujaritha Tansen, A.S.A.
Josh A. Hammerquist, A.S.A.
Xiaoxiao (Lisa) Jiang, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

L&E Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langlitz, F.S.A.
Gary R. McElwain, FLMI
Anthony G. Proulx, F.S.A.
Thomas L. Handley, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

Baltimore
David A. Palmer, C.F.E.

January 16, 2013

Arkansas Department of Insurance

RE: Kilpatrick Life Insurance Company NAIC # 74918
App.4.5.6.AR REV 12/12 Application for Life Insurance

Dear Sir or Madam:

This submission is being made on behalf of Kilpatrick Life Insurance Company. Form App.4.5.6.AR REV 12/12 is a life insurance application, updated for the new MIB requirements.

This application will be used on a general basis with approved life policies.

A similar form is being filed in the Company's domiciliary state of Louisiana.

Sincerely,

Suzanne Heasley

Suzanne Heasley, FLMI, CLU
Legal Assistant and Compliance Specialist